Local Coverage Determination (LCD): Chiropractic Services (L29099)

Contractor Information

Contractor Name	Contractor Number	Contractor Type
First Coast Service Options, Inc. opens in new window	09102	MAC - Part B

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LCD Information

Document Information

LCD ID Number
L29099

LCD Title
Chiropractic Services

Contractor's Determination Number
98940

Primary Geographic Jurisdiction
Florida

Oversight Region
Region IV

Original Determination Effective Date
For services performed on or after 02/02/2009

Original Determination Ending Date

Revision Effective Date
For services performed on or after 01/31/2012

Revision Ending Date

CMS National Coverage Policy Medicare Carriers Manual, Sections 2020.26, 2250, 2251, and 4118

Program Memorandum 932B (November 1998)

Program Memorandum 12 (Chagne Request 3063, dated 05/28/2004)

Coverage Indications Limitations and/or Medical Necessity
Chiropractic services involve manual manipulation of the spine by a licensed chiropractor to alleviate painful symptomatology due to subluxation of the spine as demonstrated by x-ray or physical exam.

Medicare will consider chiropractic manual manipulation of the spine medically necessary for a beneficiary experiencing a significant neuromusculoskeletal health problem (caused by a spinal subluxation) necessitating

manual manipulation by the Chiropractor. In addition, the manipulation must have a direct beneficial therapeutic relationship to the patient's condition. The manipulative service must provide reasonable expectation of recovery or improvement of function.

A licensed chiropractor, who meets national qualifying requirements, is a physician under Medicare Part B for one specific service. Coverage extends only to treatment by means of manual manipulation of the spine to correct a subluxation. All other services ordered or furnished by chiropractors are not covered.

In performing manual manipulation of the spine, some chiropractors use manual hand-held devices. The thrust of the force of the device is controlled manually. No additional payment is available for the device's use nor does Medicare recognize an extra charge for the device itself.

Subluxation is defined as a motion segment, in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact.

Subluxation Demonstrated by X-Ray

The subluxation must be demonstrated by an x-ray taken at a time reasonably proximate to the initiation of the course of treatment. For an acute situation, the documenting x-ray must have been taken no more than twelve (12) months prior or three (3) months following initiation of the course of treatment. In the case of chronic subluxation (e.g., scoliosis) an older x-ray may be accepted provided the beneficiary's health record indicates that the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent. Acceptable forms of x-rays include flatplates, magnetic resonance imaging (MRI) studies, and/or computerized tomography (CT) scans. A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated.

Subluxation Demonstrated by Physical Examination

To document the presence of a spinal subluxation through physical examination, two of the four criteria listed below are required. One of the criteria must be asymmetry/misalignment or range of motion abnormality.

The evaluation of the musculoskeletal/nervous system must identify:

Pain/tenderness evaluated in terms of location, quality, and intensity; or

Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); or

Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament; or

Asymmetry/misalignment identified on a sectional or segmental level.

Most spinal joint problems may be categorized as follows:

Acute subluxation - A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, orarrest of progression, of the patient's condition.

Chronic subluxation - A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the functional status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

CMS's definition of Maintenance therapy is as follows - A treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. Chiropractic maintenance therapy is not considered to be medically reasonable or necessary under the Medicare program, and is therefore not payable.

Dynamic thrust is the therapeutic force or maneuver delivered by the physician during manipulation in the anatomic region of involvement. A relative contraindication is a condition that adds significant risk of injury to the patient from dynamic thrust, but does not rule out the use of dynamic thrust. The doctor should discuss the risk with the patient and record this in the chart. However, the presence of several specific health conditions

absolutely contraindicates dynamic thrust near the site of the demonstrated subluxation and proposed manipulation. When the medical record supports the presence of an absolute contraindication near the site of the demonstrated subluxation and proposed manipulation, the chiropractic manual manipulation will not be considered medically necessary.

The following table itemizes relative and absolute contraindications to dynamic thrust.

Relative Contraindications

Articular hypermobility and circumstances where the stability of the joint is uncertain

Severe demineralization of bone

Benign bone tumors of the spine

Bleeding disorders and anticoagulant therapy

Radiculopathy with progressive neurological signs

Absolute Contraindications

Acute arthropathies characterized by acute inflammation and ligamentous laxity and anatomic subluxation or dislocation including acute rheumatoid arthritis and ankylosing spondylitis

Acute fractures and dislocations or healed fractures and dislocations with signs of instability

An unstable os odontoideum

Malignancies that involve the vertebral column

Infections of bones or joints of the vertebral column

Signs and symptoms of myelopathy or cauda equina syndrome

For cervical spinal manipulations, vertebrobasilar insufficiency syndrome

A significant major artery aneurysm near the proposed manipulation

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Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

99999 Not Applicable

CPT/HCPCS Codes

98940 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 1-2 REGIONS
98941 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 3-4 REGIONS
98942 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 5 REGIONS
98943 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); EXTRASPINAL, 1 OR MORE REGIONS

ICD-9 Codes that Support Medical Necessity

346.00 - 346.93 opens in new window	MIGRAINE WITH AURA, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITHOUT MENTION OF STATUS MIGRAINOSUS - MIGRAINE, UNSPECIFIED, WITH INTRACTABLE MIGRAINE, SO STATED, WITH STATUS MIGRAINOSUS
350.1 - 350.9 opens in new window	TRIGEMINAL NEURALGIA - TRIGEMINAL NERVE DISORDER UNSPECIFIED
352.0 - 352.9 opens in new window	DISORDERS OF OLFACTORY (1ST) NERVE - UNSPECIFIED DISORDER OF CRANIAL NERVES
353.0	BRACHIAL PLEXUS LESIONS
353.1	LUMBOSACRAL PLEXUS LESIONS
353.2	CERVICAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.3	THORACIC ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.4	LUMBOSACRAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.8	OTHER NERVE ROOT AND PLEXUS DISORDERS
355.0	LESION OF SCIATIC NERVE
355.1	MERALGIA PARESTHETICA
356.0	HEREDITARY PERIPHERAL NEUROPATHY
356.1	PERONEAL MUSCULAR ATROPHY
356.4	IDIOPATHIC PROGRESSIVE POLYNEUROPATHY
356.8	OTHER SPECIFIED IDIOPATHIC PERIPHERAL NEUROPATHY
715.00	OSTEOARTHROSIS GENERALIZED INVOLVING UNSPECIFIED SITE
715.09	OSTEOARTHROSIS GENERALIZED INVOLVING MULTIPLE SITES
715.10	OSTEOARTHROSIS LOCALIZED PRIMARY INVOLVING UNSPECIFIED SITE
715.18	OSTEOARTHROSIS LOCALIZED PRIMARY INVOLVING OTHER SPECIFIED SITES
715.20	OSTEOARTHROSIS LOCALIZED SECONDARY INVOLVING UNSPECIFIED SITE
715.28	OSTEOARTHROSIS LOCALIZED SECONDARY INVOLVING OTHER SPECIFIED SITES
715.30	OSTEOARTHROSIS LOCALIZED NOT SPECIFIED WHETHER PRIMARY OR SECONDARY INVOLVING UNSPECIFIED SITE
715.38	OSTEOARTHROSIS LOCALIZED NOT SPECIFIED WHETHER PRIMARY OR SECONDARY INVOLVING OTHER SPECIFIED SITES
715.80	OSTEOARTHROSIS INVOLVING OR WITH MORE THAN ONE SITE BUT NOT SPECIFIED AS GENERALIZED AND INVOLVING UNSPECIFIED SITE
715.89	OSTEOARTHROSIS INVOLVING OR WITH MULTIPLE SITES BUT NOT SPECIFIED AS GENERALIZED
715.90	OSTEOARTHROSIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED INVOLVING UNSPECIFIED SITE
716.10	TRAUMATIC ARTHROPATHY SITE UNSPECIFIED
716.90	UNSPECIFIED ARTHROPATHY SITE UNSPECIFIED
719.48	PAIN IN JOINT INVOLVING OTHER SPECIFIED SITES
720.0	ANKYLOSING SPONDYLITIS
720.1	SPINAL ENTHESOPATHY
720.2	SACROILIITIS NOT ELSEWHERE CLASSIFIED
720.81	INFLAMMATORY SPONDYLOPATHIES IN DISEASES CLASSIFIED ELSEWHERE
720.9	UNSPECIFIED INFLAMMATORY SPONDYLOPATHY
721.0 - 721.91 opens in new window	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY - SPONDYLOSIS OF UNSPECIFIED SITE WITH MYELOPATHY
722.0	DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.10 - 722.11 opens in new window	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY - DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC WITHOUT MYELOPATHY

722.2	DISPLACEMENT OF INTERVERTEBRAL DISC SITE UNSPECIFIED WITHOUT MYELOPATHY
722.30 - 722.32 opens in new window	SCHMORL'S NODES OF UNSPECIFIED REGION - SCHMORL'S NODES OF LUMBAR REGION
722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL DISC
722.51 - 722.52 opens in new window	DEGENERATION OF THORACIC OR THORACOLUMBAR INTERVERTEBRAL DISC - DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
722.70 - 722.73 opens in new window	INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY UNSPECIFIED REGION - INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY LUMBAR REGION
722.80 - 722.83 opens in new window	POSTLAMINECTOMY SYNDROME OF UNSPECIFIED REGION - POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
722.90 - 722.93 opens in new window	OTHER AND UNSPECIFIED DISC DISORDER OF UNSPECIFIED REGION - OTHER AND UNSPECIFIED DISC DISORDER OF LUMBAR REGION
723.0 - 723.9 opens in new window	SPINAL STENOSIS IN CERVICAL REGION - UNSPECIFIED MUSCULOSKELETAL DISORDERS AND SYMPTOMS REFERABLE TO NECK
724.00 - 724.09 opens in new window	SPINAL STENOSIS OF UNSPECIFIED REGION - SPINAL STENOSIS OF OTHER REGION
724.1	PAIN IN THORACIC SPINE
724.2	LUMBAGO
724.3	SCIATICA
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED
724.5	BACKACHE UNSPECIFIED
724.6	DISORDERS OF SACRUM
724.71	HYPERMOBILITY OF COCCYX
724.79	OTHER DISORDERS OF COCCYX
724.8	OTHER SYMPTOMS REFERABLE TO BACK
726.5	ENTHESOPATHY OF HIP REGION
726.90	ENTHESOPATHY OF UNSPECIFIED SITE
728.10	CALCIFICATION AND OSSIFICATION UNSPECIFIED
728.11	PROGRESSIVE MYOSITIS OSSIFICANS
728.12	TRAUMATIC MYOSITIS OSSIFICANS
728.2	MUSCULAR WASTING AND DISUSE ATROPHY NOT ELSEWHERE CLASSIFIED
728.3	OTHER SPECIFIC MUSCLE DISORDERS
728.4	LAXITY OF LIGAMENT
728.5	HYPERMOBILITY SYNDROME
728.81	INTERSTITIAL MYOSITIS
728.85	SPASM OF MUSCLE
729.0	RHEUMATISM UNSPECIFIED AND FIBROSITIS
729.1	MYALGIA AND MYOSITIS UNSPECIFIED
729.2	NEURALGIA NEURITIS AND RADICULITIS UNSPECIFIED
733.00 - 733.09 opens in new window	OSTEOPOROSIS UNSPECIFIED - OTHER OSTEOPOROSIS
737.0	ADOLESCENT POSTURAL KYPHOSIS
737.10	KYPHOSIS (ACQUIRED) (POSTURAL)
737.12	KYPHOSIS POSTLAMINECTOMY
737.20 - 737.22 opens in new window	LORDOSIS (ACQUIRED) (POSTURAL) - OTHER POSTSURGICAL LORDOSIS
737.30	SCOLIOSIS (AND KYPHOSCOLIOSIS) IDIOPATHIC
737.31	RESOLVING INFANTILE IDIOPATHIC SCOLIOSIS
737.32	PROGRESSIVE INFANTILE IDIOPATHIC SCOLIOSIS
737.34	THORACOGENIC SCOLIOSIS
737.8	OTHER CURVATURES OF SPINE ASSOCIATED WITH OTHER CONDITIONS
738.2	ACQUIRED DEFORMITY OF NECK
738.4	ACQUIRED SPONDYLOLISTHESIS

738.6	ACQUIRED DEFORMITY OF PELVIS
756.11 - 756.17 opens in new window	CONGENITAL SPONDYLOLYSIS LUMBOSACRAL REGION - SPINA BIFIDA OCCULTA
756.2	CERVICAL RIB
784.0	HEADACHE
846.0 - 846.8 opens in new window	LUMBOSACRAL (JOINT) (LIGAMENT) SPRAIN - OTHER SPECIFIED SITES OF SACROILIAC REGION SPRAIN
847.0 - 847.4 opens in new window	NECK SPRAIN - SPRAIN OF COCCYX
848.3	SPRAIN OF RIBS
848.41	STERNOCLAVICULAR (JOINT) (LIGAMENT) SPRAIN
848.42	CHONDROSTERNAL (JOINT) SPRAIN
848.5	PELVIC SPRAIN
905.1	LATE EFFECT OF FRACTURE OF SPINE AND TRUNK WITHOUT SPINAL CORD LESION
905.6	LATE EFFECT OF DISLOCATION
907.3	LATE EFFECT OF INJURY TO NERVE ROOT(S) SPINAL PLEXUS(ES) AND OTHER NERVES OF TRUNK
953.0 - 953.5 opens in new window	INJURY TO CERVICAL NERVE ROOT - INJURY TO LUMBOSACRAL PLEXUS
954.0	INJURY TO CERVICAL SYMPATHETIC NERVE EXCLUDING SHOULDER AND PELVIC GIRDLES
954.1	INJURY TO OTHER SYMPATHETIC NERVE EXCLUDING SHOULDER AND PELVIC GIRDLES
956.0	INJURY TO SCIATIC NERVE

Diagnoses that Support Medical Necessity
N/A

ICD-9 Codes that DO NOT Support Medical Necessity
N/A
XX000 Not Applicable

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity
N/A
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General Information

Documentation Requirements
The following documentation must be maintained in the patient's file. The documentation must be legible.

Initial Visit - The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical exam:

1. History should include the following -

The symptoms causing the patient to seek treatment;

The family history if relevant;

The past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history);

The mechanism of trauma;

The quality and character of symptoms/problem;

The onset, duration, intensity, frequency, location and radiation of symptoms;

Aggravating or relieving factors; and

Prior interventions, treatments, medications, secondary complaints.

2. Description of the present illness including -

The mechanism of trauma;

The quality and character of symptoms/problem;

The onset, duration, intensity, frequency, location, and radiation of symptoms;

Any aggravating or relieving factors;

Prior interventions, treatments, medications, secondary complaints; and

The symptoms causing the patient to seek treatment.

NOTE: These symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine (spondyle or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal) and joint (arthro) and be reported as pain (algia), inflammation (itis), or as signs such as swelling, spasticity, etc. Vertebral pinching of spinal nerves may cause headaches, arm, shoulder and hand problems as well as leg and foot pains and numbness. Rib and rib/chest pains are also recognized symptoms, but in general other symptoms must relate to the spine as such. The subluxation must be causal, i.e., the symptoms must be related to the level of the subluxation that has been cited in the medical record. A statement on a claim that there is "pain" is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.

3. Evaluation of musculoskeletal/nervous system through physical examination. The criteria identified under the "Indications and Limitations etc." section must be present.

4. Diagnosis - The primary diagnosis must support the physical findings of subluxation, including the precise level of subluxation, either so stated or identified in the medical record by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named. The precise level of the subluxation may be specified in the medical record by the exact bones (C5, C6, etc.) or the area may suffice if it implies only certain bones such as occipito-atlantal (occiput & C1[atlas]), lumbo-sacral (L5 and Sacrum) or sacro-iliac (sacrum and ilium).

Examples of acceptable descriptive term, for the nature of the abnormality/subluxation:

off centered misalignment lithiasis
-antero
-postero
-retro
-lateral
-spondylo

motion
-limited
-lost
-restricted
-flexion
-extension
-hypermobility
-hypomotility
-aberrant

malpositioning
rotation
incomplete dislocation
spacing
-abnormal

-altered
-decreased
-increased

Other terms may be used if they are clear to mean bone/joint space, position or motion changes of the vertebral elements.

The precise level of subluxation is made in relation to the part of the spine in which the subluxation is identified:

Area of Spine - **Names of Vertebrae** - Number of Vertebrae - **Short Form or Other Name**

Neck - **Occiput, Cervical, Atlas, Axis** - 7 - **Occ, CO, CI thru C7, C1, C2**

Back - **Dorsal or Thoracic, Costovertebral, Costotransverse** - 12 - **D1 thru D12, T1 thru T12, R1 thru R12, R1 thru R12**

Low Back - **Lumbar** - 5 - **L1 thru L5**

Pelvis - **Ilii, right and left** - **I, Si**

Sacral - **Sacrum, Coccyx** - **S, SC**

In addition to the vertebrae and pelvic bones listed, the Ilii (R and L) are included with the sacrum as an area where a condition may occur which would be appropriate for chiropractic manipulative treatment.

5. Treatment Plan - The treatment plan should include the following:

Recommended level of care (duration and frequency of visits);

Specific treatment goals; and

Objective measures to evaluate treatment effectiveness.

6. Date of the initial treatment or date of exacerbation or reinjury of the existing condition.

Subsequent Visits - the following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

1. History -

Review of chief complaint;

Changes since last visit; and

System review if relevant.

2. Physical exam -

Exam of area of spine involved in diagnosis;

Assessment of change in patient condition since last visit; and

Evaluation of treatment effectiveness.

3. Documentation of treatment given on day of visit.

Acceptable terminology for spinal manipulation treatments usually includes:

· Manual adjustment, correction or manipulation

· Spinal adjustment, correction or manipulation

· Vertebral adjustment, correction or manipulation

· Manipulation of spine by chiropractor activator

· Spine or spinal adjustment by manual means

· Correction equals treatment

4. Any changes in the treatment plan.

The following documentation requirement applies to subluxations demonstrated by x-ray:

The x-ray must be in one of the following forms – flat plate, MRI or CT Scan. The x-ray must be dated and demonstrate the precise level of the spinal subluxation.

An x-ray obtained by the chiropractor for his own diagnostic purposes before commencing treatment should suffice for claims documentation purposes. However, when subluxation was for treatment purposes and diagnosed by some other means and x-rays are taken to satisfy Medicare's documentation requirement, carriers should ask chiropractors to hone in on the site of the subluxation in producing x-rays. Such a practice would not only minimize the exposure of the patient but also should result in a film more clearly portraying the subluxation. An x-ray will be considered of acceptable technical quality if any individual trained in the reading of x-rays could recognize a subluxation if present.

The x-ray report, indicated by the date documented on the CMS Form 1500, must be available for carrier review. The report must demonstrate the existence of the subluxation at the specified level of the spine.

In the event of a medical record review, the x-ray report must be submitted. The actual x-ray films are to be

maintained by the chiropractor.

Appendices

Utilization Guidelines The chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration of subluxation within a reasonable and generally predictable period of time. Acute subluxation (e.g., strains or sprains) problems may require as many as 3 months of treatment but some require very little treatment. In the first several days, treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained. Chronic spinal joint condition (e.g., loss of joint mobility or other joint problems) implies, of course, the condition has existed for a longer period of time and that, in all probability, the involved joints have already "set" and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

Some chiropractors have been identified as using an "intensive care" concept of treatment. Under this approach, multiple daily visits (as many as four or five in a single day) are given in the office or clinic and so-called room or ward fees are charged since the patient is confined to bed usually for the day. The room or ward fees are not covered and reimbursement under Medicare will be limited to not more than one treatment per day.

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for

medical necessity.

Sources of Information and Basis for Decision

N/A Advisory Committee Meeting Notes This Local Coverage Determination (LCD) does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this LCD was developed in cooperation with the advisory groups, which includes representatives from numerous societies.

Start Date of Comment Period End Date of Comment Period

Start Date of Notice Period 12/04/2008

Revision History Number 1
Revision History Explanation Revision Number:1

Start Date of Comment Period:N/A
Start Date of Notice Period:04/01/2012
Revised Effective Date:01/31/2012

LCR B2012-030
March 2012 Connection

Explanation of Revision: Removed reference to documentation being required in English from the "Documentation Requirements" section of the LCD. The effective date of this revision is based on process date.

Revision Number:Original
Start Date of Comment Period:N/A
Start Date of Notice Period:12/04/2008
Revised Effective Date:02/02/2009

LCR B2009-
December 2008 Bulletin

This LCD consolidates and replaces all previous policies and publications on this subject by the carrier predecessors of First Coast Service Options, Inc. (Triple S and FCSO).

For Florida (00590) this LCD (L29099) replaces LCD L6026 as the policy in notice. This document (L29099) is effective on 02/02/2009.

08/08/2009 - This policy was updated by the ICD-9 2009-2010 Annual Update.

09/06/2010 - This policy was updated by the ICD-9 2010-2011 Annual Update.

11/25/2012 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document:
98940 descriptor was changed in Group 1
98941 descriptor was changed in Group 1
98942 descriptor was changed in Group 1
98943 descriptor was changed in Group 1

Reason for Change

Related Documents This LCD has no Related Documents. LCD Attachments Coding Guidelines opens in new window Back to Top

All Versions

Updated on 11/25/2012 with effective dates 01/31/2012 - N/A Updated on 03/15/2012 with effective dates 01/31/2012 - N/A Updated on 08/08/2009 with effective dates 02/02/2009 - N/A Updated on 11/30/2008 with effective dates 02/02/2009 - N/A Read the **LCD Disclaimer opens in new window** Back to Top